

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE  
DEATH OF A MAN AT HMP GLOUCESTER IN FEBRUARY 2005**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**December 2005**

This is the report of an investigation into the circumstances surrounding the death of a man at HM Prison Gloucester in February 2005. The man was found dead in his cell that day. A bed sheet had been fashioned into a noose and was wrapped tightly around his neck. A letter, apparently written by him on the night he died, gave some indication as to his state of mind. It described his feelings of hopelessness at the thought of not seeing his son for a long time, or his estranged partner ever again, and expressed his intention to take his own life.

The post mortem examination found that the provisional cause of death was, 'Pressure to neck – consistent with hanging'. The pathologist called for a toxicology report. On 15 April he examined the report, dated 22 March. All results were negative.

I offer my sincere sympathy and condolences to the man's family who have suffered the tragic loss of a much loved member of their family. I know that the staff at Gloucester shares the sense of loss.

This investigation was carried out on my behalf by two of my colleagues. As part of their investigation they commissioned an independent review into the clinical management of this man. I am grateful to the clinical reviewer who carried out the review on behalf of the West Gloucestershire Primary Care Trust.

My thanks also go the Governor and all Gloucester staff. I appreciate their willing cooperation which has enabled the investigation to be thorough yet completed in a timely fashion. Although the way in which the man's parents learned of their son's death was very unfortunate, this seems to have been due to a breakdown in communication between the prison and the police. In other respects the prison has behaved very sensitively – led personally by the Governor, whose actions I am pleased to commend here and elsewhere in the report. I have also drawn attention to the professional actions of other staff.

On the information the prison had, I do not think anyone could have anticipated that the man was at special risk of taking his own life.

I make six recommendations.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**December 2005**

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## Summary

The man was a 37 year old man, and his family is made up of mother, father and one sister. His early upbringing was straightforward and without anxiety. On leaving school he had several short-term jobs but spent long periods without work. He had two children, both boys. The first son, born about four years ago was adopted shortly after birth. The second son is three years old. He lives with his mother from whom the man was separated, but is very much part of the man's family.

At the time of his death the man had served several prison sentences. He had, however, been out of trouble for two-and-a-half years and appeared to be making good efforts to live a law-abiding life. His last work venture as a photographer, funded by his parents, seemed to be going well.

In February 2005, the man was charged with burglary by the police and remanded in their custody. He was taken to the Police Station where he remained until his transfer to HM Prison Gloucester on 19 February. Although the man did not give any indication that he would harm himself, the police noted he had made a suicide attempt some years earlier and they put him on a 'special watch'. Although they noted these events in the narrative of the custody record, they did not highlight, in the designated area of the Prisoner Escort Record (PER), either their knowledge of his previous attempt on his life or details of the special watch which they maintained throughout the time he was in police custody. These pieces of important information were subsequently not brought to the attention of the escort contractor or the staff at Gloucester. The matter of the police documentation is the subject of an investigation by the Independent Police Complaints Commission (IPCC).

When the man arrived at Gloucester, staff noticed his flatness of mood and anger with himself for once again being in prison. They noted also his worry that he was unlikely to see his son for some time. A reception officer and a nurse interviewed and questioned the man who assured them he would not harm himself. On the residential wing, staff cared well for him over the two days he was in prison. The man requested and was allocated to a single cell. Given they had no knowledge of his previous suicide attempt, nor of the special watch at the police station, staff took all reasonable steps to ensure his wellbeing. The man was last seen alive at about 8.10pm on 20 February.

On 21 February 2005 at 5.15am, the night duty officer making an early morning roll check found him hanging from his cell bars. A bed sheet had been torn and fashioned into a noose. Nursing and medical staff attended promptly and, although they tried to resuscitate him, it soon became clear that he was dead. Death was certified at 6.30am. Contingency plans were implemented quickly. The Governor led personally, ensuring that staff and other prisoners were cared for and counselled and he immediately wrote a message to staff and prisoners.

The way in which the man's parents learned of the death of their son was very regrettable. The family lives some 80 miles from the prison and the Governor asked

Nuneaton police to break the news and ask the man's parents to telephone the prison. When the police arrived, the mother was looking after her seven year old grandson at home. No one else was in the house. The man's mother was asked simply to telephone the prison. She was not given a reason. It came as a great shock to be told by telephone that her son was dead. This was a distressing and inappropriate way to learn of her son's death.

It is impossible to say with certainty what the man's intentions were when he wrapped a bed sheet around his neck. However, the letter he left gives a good indication of his state of mind and his intention to kill himself. He had said earlier to staff that he was angry at finding himself back in prison, and he had expressed anxiety that he would not see his small son for some time. It seems he felt hopeless enough to take his own life.

## **Investigation methodology**

The investigation was opened on February 2005 when the investigators met with the Governor and Safer Custody Manager at Gloucester. They were given a comprehensive and very helpful briefing on the events leading up to and after the man's death. Ombudsman's notices, identifying the scope and methodology of the investigation, were issued to staff and prisoners. The notices also made clear that staff or prisoners who wished to see my investigators should make themselves known by either contacting the investigators' liaison officer at the prison, or by contacting my office direct. Staff and prisoners in key positions or locations were identified by my investigators and were invited for interview. All responded willingly. The local branch of the Prison Officers' Association (POA) was briefed. They were helpful and offered constructive comment and advice. During four follow-up visits, my investigators interviewed four members of staff and two prisoners.

The investigators met with the Chair of the Independent Monitoring Board (IMB) at the prison. His contribution was valuable and provided an independent perspective on the prison.

The investigators met local police. They shared freely all their information and interview records, as did the coroner's officer.

The investigators commissioned an independent clinical review. This was conducted by a clinical reviewer of the West Gloucestershire Primary Care Trust.

The lead investigator, together with one of my family liaison officers met the man's family at home. They were made to feel very welcome and the man's parents added a great deal to their knowledge and understanding of the man's life.

The investigators met with the Regional Commissioner for the Independent Police Complaints Commission, and with a senior investigator, at the IPCC offices in Coleshill. They later met a senior police officer from Somerset and Avon force, acting on behalf of IPCC.

The lead investigator met the solicitor for the POA, at her request, and explained the procedure for the investigation.

## **HMP Gloucester**

HMP Gloucester opened in 1782. The present buildings date from 1840. The prison is a typical example of Victorian architecture, solid brick and built to last. Modifications and additions, most recently in 1971 when a new wing was added, have enlarged and improved the prison, which provides good conditions and training programmes for prisoners. A total of 320 prisoners can be held there. At the time of this investigation, the prison roll was 267.

Gloucester is subject currently to a programme known as Performance Improvement Planning. This programme helps a prison assessed as level 2 or 1, to improve its performance. (Performance is marked on a 4 point scale, with 4 points being the best rating.) A team led by the Prison Service Area Manager reviews all aspects of delivery and sets new targets which challenge the establishment to tackle specific areas for improvement. The establishment is given support to develop an implementation plan setting out how the improvements will be achieved. If performance does not improve to the required level, the establishment will be nominated as a candidate for Performance Testing.

Three prisoners, two of whom were unconvicted, died within an 18 day period in February 2004, all by hanging. Inquests on all three prisoners were held between 9-12 May 2005. In each case, the jury returned verdicts of 'suicide'. There were no riders to the verdicts and no blame was attached to the prison.

HM Chief Inspector of Prisons, and the Prison Service's Standards Audit Unit (SAU) inspected separately but around the same time in November/December 2003. Both reports identified Gloucester's performance as patchy. SAU identified as unacceptable the programme of induction for prisoners. They re-audited selectively in December 2004. Although the induction programme was not re-audited, the Governor had by that time completely redesigned the programme and increased its duration to five days. He is confident that if an audit were conducted now, it would find the induction arrangements for prisoners to be comprehensive and of a high standard.

My investigators examined the induction programme and agree it is comprehensive and well put together. Its one defect is that it has no formal activity at weekend. This is mitigated in that prisoners who arrive during the weekend are given immediate access to telephones, provided with full induction information and given special pastoral attention by wing staff, prior to joining the formal programme on the Monday.

The Chair of the Independent Monitoring Board told my investigators that Gloucester had learned valuable lessons from the deaths of 2004 and had 'put tremendous work' into revitalising the whole programme of suicide and self-harm arrangements. Personal care by staff was in his view of the highest standard, and documentation had been refreshed in order to provide an audit trail which could be easily followed when staff handed over from one shift to another. His only reservation was that the induction

programme did not operate formally at weekends, although he was aware of the intensive support provided during weekends by the chaplain and wing staff.

My investigators reviewed Safer Custody practice at Gloucester and found that the Prison Service requirements were met and often exceeded. Staff were aware of the F2052SH (monitoring people at risk) system and of the need to act quickly should they suspect any prisoner might be thinking of self harm. Gloucester averages two or three open cases daily. The open documents were checked and found to be up to date, with good quality records of activity together with comprehensive notes in the daily supervision and support record.

Information is displayed widely in all areas of the prison and includes details of how staff can help prisoners. The Listeners scheme is also explained. This is an arrangement where prisoners who have problems, but feel unable to talk to staff, can talk to other prisoners who have been specially chosen and trained. There is also comprehensive written information on how to contact Samaritans. The telephone booths on the wings have the Samaritan message and free phone number displayed prominently.

The Safer Custody Group meets every two months. It is chaired by the head of residence (a governor grade) and attended by staff and Listeners. Suicide Awareness is a standing agenda item, as are Listeners' reports and examination of F2052SH (self harm) statistics. The meeting is well attended but there is one regular notable absentee. The representative of the escort and custody contractor (Reliance) is a member of the meeting, but has not attended for many months. Successive meetings have noted this and attempted to secure the attendance of a representative, but no one has attended since May 2004.

## **Events leading up to the man's death**

The man was arrested in February 2005 for alleged offences of burglary and taken to the police station. He was transferred during the afternoon of the same day to another police station and he remained there until 19 February when he appeared before the Magistrates Court.

It is necessary at this point to explain the custody and escort documentation, as it features prominently in the events leading to the man's death. The definitive document is the Prisoner Escort Record (PER) on which all information in respect of a prisoner in custody is recorded by police, escorting contractors and Prison Service staff.

Prison Service Order (PSO) 1025, dated September 2000, introduced the PER as the standard form for communicating risk on escort or transfer. The PSO gives detailed information to police and escort contractors on how to complete the form. Chapter 3, paragraph 4 of the Order says 'identification of suicide or self harm risk is one of the prime purposes of the PER'.

The PER accompanies a prisoner at all stages of his or her custody. The form is divided into two parts. Part A is especially important in that it is the front page, and is designed, through a number of 'tick boxes', to identify information of the utmost importance. Part B provides for either fuller explanation of part A or for a chronological narrative of routine events.

The PER enables police, court and prison escort contractors, to make entries on it at significant stages, and to read, update and act on information about a prisoner. The form accompanies a prisoner when he is escorted to court or prison where it is then available for court or prison reception staff to note and act upon as required.

An entry made by the police on part B of the man's Prisoner Escort (PER) at 3pm reads:-

"Pic [prisoner in custody] has warnings for violence, and a very old self harm where he tried to gas himself. He appears calm and chipper. To be on 30 minutes obs [observation]."

My investigators have made the interpretations of 'Pic' and 'obs' which appear on the PER and the words in brackets in the quoted paragraph above are theirs. The entry was written in longhand, which, although not illegible, took a few minutes to decipher. The police officer who made the entry did not tick the box on the PER part A to highlight the suicide or self harm risk.

I make a specific recommendation below about the way the man's PER was completed and handled, together with a more general one in respect of the form itself.

On Friday 18 February, the man was visited at the police station on two separate occasions by a solicitor. Following his death she asked to speak to my investigator. In a telephone conversation she told him that the man had intended to plead not guilty to the charges of burglary. On her first interview she was worried about the man's state of mind. He said he had thought about how he might kill himself while in police custody. When she asked why, he said he could not face a weekend in the police station and, as it was Friday, he was sure that she could not complete her preparation in time for him to appear in court on Saturday and be remanded to Gloucester. The solicitor decided to make a further visit during the evening so that they could be ready for court on Saturday. She said that the man expected to be remanded in custody following his court appearance. She said that at the end of the second visit she found him to be 'fine', and 'very happy'. The solicitor said on leaving the police station she had 'no anxieties whatsoever'. She did not bring her earlier worries to anybody's attention.

The man was collected on Saturday 19 February from the police station and escorted to court by Reliance staff, the court and custody contractor for the area. When custody is transferred from one agency to another, there is a formal hand-over. The identity of the prisoner is checked, documents are given to the escorting officer and personal property is collected. The PER is passed to the contractor, who should examine the form for information of importance, then sign it as formal acceptance of responsibility for the custody of the prisoner. In the man's case, a Prisoner Custody Officer (PCO), a member of Reliance staff, signed the PER.

The man appeared in court on Saturday morning, 19 February. He was remanded in custody to prison and taken by Reliance staff to Gloucester. He arrived there at about 1.30pm. He was seen initially by a reception officer. The officer remembers the man and recalls particularly going through the details of money and personal effects that he had brought to the prison. The reception officer noted nothing in respect of the likelihood of him harming himself, but he asked him if he felt all right in himself. The officer was satisfied that the man was not likely to self-harm. He explained to the man how he could make a telephone call to let his family know he was in Gloucester and gave him a 30p telephone credit which could be used immediately. The man elected also to have a further £5 of his own money credited to the telephone system. As it was weekend, that credit could not be used until Monday when administration staff could set up his electronic account. At Gloucester, however, there is a formal arrangement where prisoners can make all necessary calls at public expense, and the man was told of this.

Within a few minutes, the man was interviewed by the reception nurse who noted he was low in spirit and that he seemed angry with himself. She asked if there was something he wanted to share and he told her he was indeed angry with himself. Having kept out of trouble for over two years he now found himself back in prison. The nurse was careful to ask about self-harm intentions and he assured her he had none. She is very experienced, and on what she saw and heard she believed him. She does not routinely see the PER. The reception nurse would see this only if the police had marked information of importance relevant to health care in Part A of the form. The reception nurse completed a 'First Night Reception Health Screen', Form 2169, and she

made a note on the file to the effect that the man appeared flat in mood and appeared angry with himself, but that he had assured her he would not do anything suicidal. The nurse completed her part of a 'Cell Sharing Risk Assessment Form' to the effect that the man could safely share a cell with another prisoner. She passed the file to A wing where the man was to be located. Form 2169 is comprehensive. Its only shortcoming is that section 8 is unclear. Although there are boxes to be ticked, it does not require the writer to make an entry, and can be read in contradictory terms. I make a recommendation below.

In A wing the man asked for a single cell, saying he would prefer not to share as he was a non-smoker and the majority of prisoners smoke. The officer completed the residential staff part of the risk assessment, which helps wing staff to identify in what circumstance a prisoner may share a cell or be on his own. The wing was not full, the officer assessed the man could safely be located on his own and he was given a single cell.

At 2.10pm, the man tried to telephone his parents to let them know he had arrived at Gloucester. They were not at home, and five minutes later the man rang a friend who promised to let them know. It is probable that his friend told his partner, as it was she who made the call to let his parents know that the man was now in Gloucester.

The remainder of Saturday passed uneventfully. The man settled into the wing and, although described as being quiet, he talked to other prisoners and was generally thought to be all right. He apparently confided to two prisoners that he was looking at, in his own words, 'a long stretch'. Another prisoner asked him if he had any cigarette papers. The man could not help as he did not smoke. The prisoner remembers him as quiet but not somebody about whom he felt worried.

On Sunday 20 February, a prison officer worked from 8am until 7.30pm. When my investigator interviewed her, she remembered identifying him as being newly arrived on the wing and she asked him if he had been in touch with his family and whether or not she could telephone them on his behalf. He said everything was fine and he had let his family know where he was. The officer remembered that during the afternoon the man took a shower, and later asked for his cell door to be unlocked. She saw him again at about 6.30pm and asked how he was settling in the prison. He said again everything was fine. She remembered also that the man had taken and eaten his meals. She made a point of checking his meal tray after lunch and tea, and noted that it was empty on each occasion.

During the evening roll check at about 8.10pm, the night duty officer for A wing, saw him at his table watching television. As he had no reason to think the man might harm himself, the man did not look again through the cell observation panel until he made a further routine roll check at 5.15am next morning when he found the man hanging.

## **Events following the man's death**

At 5.15am on Monday 21 February, when the night duty officer opened the observation panel of the man's cell he saw immediately that the man had a piece of green bed sheet around his neck and was hanging from the window bars. The officer made an emergency call by radio and entered the cell. Other staff arrived immediately and helped cut the sheet. The staff nurse arrived within a minute or two and she attempted to revive him by resuscitation. The staff nurse could not establish an airway. She realised further treatment would not be effective and she discontinued the resuscitation process. Police arrived at the prison at 5.30am and an ambulance arrived at 5.45am. The prison doctor arrived at 6.20am and certified the man's death at 6.30am.

Present amongst the man's personal effects in the cell was a letter, written apparently to his partner and mother of his younger son. That letter showed his feelings of hopelessness, and demonstrated an intention to take his own life.

Contingency plans were put into place with good speed and notification was made to the Coroner, Independent Monitoring Board, staff Care Team leader and to everyone who needed to know. The Safer Custody governor and the governing Governor arrived at 6am and 6.15 respectively. The governor held a meeting at 7.45 for all staff who had been involved, and he wrote a note to all staff and prisoners explaining what had happened. He arranged for Nuneaton police to break the sad news to the man's family.

The prison Care Team were quickly in action and saw all staff who had been involved in the incident and its aftermath. They offered counselling and advice services and the governor also advised staff of his willingness to see them personally.

## **Clinical Review**

The Clinical Review was conducted by a clinical reviewer of the West Gloucestershire Primary Care Trust. The man had been in prison for just two days when he died and there was little clinical history. Medical records from his family doctor were not available when the reviewer's report was written. Her report noted that the man presented as a fit young man who had no physical health problems.

The Clinical Review concluded that the man's care at Gloucester was good. The reception nurse who interviewed him when he arrived at the prison was well trained and experienced, and she came to conclusions which were appropriate as a result of her reception interview with him. The nurse had noted the man's flatness of mood, and anger with himself. She had asked him what was wrong, and he had given answers which seemed reasonable. The man had also said he would not harm himself. The nurse had made comprehensive notes and she had passed these to the staff who were responsible for his residential care.

The clinical reviewer concluded that, given the nurse had neither knowledge of the man's previous self harming, nor of the special watch to which he had been subject at the police station, she had taken reasonable precautions to try to ensure he was supported appropriately in his early days in prison.

## Emerging issues

There are some worrying features arising from events leading up to the man's death. Communication left much to be desired. Pockets of information were not brought together. The police station knew of a previous suicide attempt and they maintained a special watch on him throughout his custody in the police station. They did not flag this as an important piece of information for the contractor who escorted the man to court and then to prison. A legal advisor had anxiety about his state of mind before he was transferred to prison, but did not tell anyone of her concern for his wellbeing. Prison staff too saw his unhappiness and a trawl through available documentation would have helped. But the opportunity to deal with all this in a comprehensive way was lost.

The Prisoner Escort Record does not give sufficient prominence to the likelihood of a prisoner either self-harming or committing suicide. On the one hand, the Prison Service Order says 'the identification of suicide or self harm risk is one of the prime purposes of the PER'. On the other hand, the place set aside in part A of the form to record suicide and self harm risk is shown as 'other' and falls behind space on the form allocated to enter medical or security considerations.

Escort contracts started in 1996 and the PER was issued in 2000. Although it was revised in 2004 to take account of a barcoding system for prisoner identification, it has remained largely unchanged for nearly six years. Experience gained during that time would no doubt be useful in reviewing and revising the form.

Although I sometimes come across very good practice, a number of my investigations have revealed that the way in which families are informed of the death of their loved ones leaves much to be desired. This case is no exception.

Problems arise when next of kin cannot be traced, when time between death and notification passes and concern the manner in which families are told. Prison Service Order 2710, issued in 1998, does not stress the need to leave no stone unturned in finding family details. All too often, a manuscript entry or electronic record made on reception at a prison lists a telephone number which later proves to be unavailable, but a chaplain, a record of visits or a probation officer will identify immediately an up to date contact point. I think it may fairly be added that an examination of a prisoner's telephone PIN records never fails.

Problems also arise on occasions when the police are the bearers of news of death to a family. Prison Service Order 2710 gives some guidance to Governors, but it does not go far enough. Governors interpret differently the guidance about their personal obligation to inform the family unless the distance or time involved in doing so makes it necessary to ask the police. (In one case a distance of 15 miles, and travelling time of one hour were considered sufficient reason to pass the duty to the police.) There is no formal arrangement for contacting police and there is no protocol in respect of what the police should say. In this case, the governor thought the police would tell the man's

family of his death. The police thought they simply had to tell the family to telephone the prison.

PSO 2710 also says that, where possible, the governing Governor should visit and tell the family of the death of a prisoner. Although this duty can be delegated, it seems in most cases routinely to be passed to someone at the prison other than the governing Governor. In some jails, it also seems that the police are being used as a matter of course, as distinct from exception, for breaking the news.

I make a recommendation below in respect of revision of Prison Service Order 2710

## Conclusions

The man had been to prison before. He would have known what to expect. But this time was different. He had lived within the law for over two years and had made a life for himself in the community. He had started work on his own account. His relationship with the mother of his son was variable, sometimes good, usually difficult. But he had his son and, if life was not perfect, it was better than it had been for some years. Then the bottom dropped out of his world and he was back in custody in a police station and expecting, by his own account, a long prison sentence. The future looked bleak, and if he was to have a chance to emerge intact, it needed all available information to be integrated in order to make a comprehensive plan for his care. The man too, had to contribute. People could not read his mind and, although several people made good attempts to do the right things, his assurance that he would not harm himself was taken in good faith.

The police station should have given prominence on Part A of the PER to their knowledge that the man had made a previous attempt on his life, and that for several days they had kept him on a special watch. They had sufficient anxiety to place him on a special watch, and it follows that this should have been highlighted on Part A of the PER (the front page) and brought to the attention of the escort contractor's staff. The escort contractor in turn could have alerted reception staff at Gloucester. Because this was not done, the contractor and the prison reception staff did not read beyond Part A and the information was lost.

The man's solicitor could have told the police that he had talked about killing himself. Even though she thought later that he was all right, a word from her would have provided information, and added weight and anxiety about his state of mind.

It is likely that, if they had been aware of the police information, and that held by the solicitor, Gloucester staff would have paid more attention to the man's condition, probably arranging a special self-harm programme. At the very least, if information which was available from a number of sources had been shared and amalgamated, a different picture of his state of mind would have been seen.

It is possible to say that prison staff should have gone behind the headlines of the PER and read on through the narrative. In practice, this is an unreasonable expectation. Given the amount of paperwork received and subsequently generated for each prisoner, I think it was pardonable for reception staff to take the Prisoner Escort Record at face value. There was nothing in the place set aside on the form to indicate the likelihood of the man harming himself. The reception officer asked him about self harm. He was interviewed formally and at length by an experienced nurse who used the appropriate forms and her own good sense and judgement in making her assessment. She telephoned the prison wing and she passed on her written report. On the wing, care for the man was good. Staff spoke to him several times over the weekend, and they made sure he had contacted his family and that he had eaten his meals. The prison officer in particular impressed my investigators as diligent and caring. She knew the first hours

and days after reception into prison could be difficult and she went out of her way to check with him that he was coping.

All staff on duty at Gloucester had only limited knowledge of the man. They did not know of his previous attempt on his life. Neither did they know of the police watch or of his solicitor's anxiety. Given the circumstances, they did all that could have been expected of them and they should not reproach themselves in any way in respect of the sad circumstances of the man's death.

It is not possible to say authoritatively what the man's intentions were when he wrapped a bed sheet round his neck or what motivated his actions. However, my investigation has identified him as being troubled and depressed. His own prediction was that he would spend some years in prison and not see his son during his sentence. The letter he wrote to his partner identified his intention to end his life.

## **Recommendations**

### For the Prison Service, Police and Court Escort and Custody Contractors

1. The Prison Service, Police and the Court Escort and Custody contractors should review and revise the Prisoner Escort Record, in order to ensure greater prominence is given on the form to information relating to self-harm and suicide risk.
2. Prison Service Order 2710 should be reviewed and revised. Chapter 3 says that notification to the deceased's family should be made (unless there are good reasons not to) by the Governor and Chaplain or religious leader. The revision should
  - reinforce the requirement, or vary it if it is thought that someone other than the Governor may reasonably inform the family. A suitable alternative to the Governor might be the Safer Custody Manager;
  - give further guidance on the issues of time and distance. While I am mindful of the many pressures on Governors, it is impossible to overstate the value of a personal visit to a bereaved family;
  - address and resolve problems which can occur when police make the notification, by introducing a protocol or pro forma setting out the extent and detail of the information which is to be passed to the family;
  - give detailed guidance in respect of the need for strenuous effort to be made to make early contact with the family.
3. The form F2169 (Health Screen) should be reviewed as a whole, and revised at section 8. In its present form it is ambiguous and can lead to important omissions.

### For Hereford Police Force

4. I recommend that a copy of this report is sent to Hereford Constabulary so that Hereford custody officers can be reminded of the importance of entering information on Part A of the Prisoner Escort Record.

### For HM Prison Gloucester

5. The reception nurse should see routinely the Prisoner Escort Record.

### For Reliance Court Escorts and Custody Contractor

6. Reliance should reinstate their representation at the Gloucester Suicide and Self Harm meeting.